Quality Project HIV Best Practices Briefer #1

Strengthening Access to HIV Prevention, Care and Treatment in Areas With High Concentrations of Key Populations

Background

The Central Asian HIV epidemics are primarily concentrated amongst key populations, including people who inject drugs (PWID), sex workers (SW) and men who have sex with men (MSM). These groups all tend to be more prevalent in urban environments, and as a result countries such as Kazakhstan, Kyrgyzstan and Tajikistan have seen the largest incidence of HIV in capital cities and other major urban centers. In these geographic areas with high concentrations of key populations, a unique and designated approach is needed to reach out to and engage these populations in HIV prevention, testing, treatment and care.

Over the last decade, international donors have invested considerable funds in the development of outreach programs, primarily through non-governmental organizations (NGOs), and have also designated more limited effort to supporting the improvement of state health care services. As government-run health systems continue to decline in the post-Soviet era, the imbalance of resources flowing to NGOs versus governmental organizations has created a rift between civil society and government services; these ill feelings between the two sectors have contributed, in many cases, to gaps in the continuum of care for key populations, who have trouble navigating from NGO outreach into medical care.

Lack of a structured mechanism for positive, constructive dialogue between NGOs and government providers, lack of sustainable referral systems and/or integrated services, and gaps in both NGO and government service provider capacity were all factors identified by the Quality Project as exacerbating this issue. In response, an approach was developed to provide intensive support in key localities in each country, effectively improving access to care in the places where it was needed most, while also identifying effective best practices to be scaled to the national level in each country.

Implementation Details

The Quality Project engaged in three core areas of work in each targeted geographic area, though, as described below, adaptation of the approach varied by setting to assure local needs were met.

Establishment of Coordination Councils

In order to promote increased communication and collaboration between governmental and non-governmental partners in serving key populations, Coordination Councils of local program implementers were formed with support from the Quality Project, and met at least quarterly. Meetings focused on identifying barriers to serving key populations, and devising locally-driven solutions, which could be implemented with targeted support from the Quality Project.

Promoting Integrated Services

Working alongside the Coordination Councils to identify specific priorities in their localities, the Quality Project supported integration of services such as HIV testing and counseling, risk reduction counseling, needle & syringe exchange, and other key population-targeted services at the primary care level, where a wider range of services would already be available for clients seeking HIV-related prevention or care. In some cases, where local resources permitted, the project promoted the use of government multi-disciplinary teams through mobile units to provide services at NGOs (Tajikistan) and supported on-site peer-to-peer counseling (Kazakhstan, Kyrgyzstan), or colocation of two or more major medical services, such as TB screening and medication assisted treatment for opioid dependence (Tajikistan).

Capacity Building

In order to support implementation improvements as identified by the Coordination Councils and suggested by international standards on integration, the Quality Project provided a range of technical and managerial trainings to both government and NGO workers. Topics included human resource management; technical management of HIV prevention care and treatment programs for PWID, MSM and SW (three separate trainings); MAT program implementation dialogues; overdose prevention as part of HIV prevention; introduction of gender-sensitive approaches for harm reduction, and basic capacity building for the PLHIV community. Many trainings engaged mixed audiences with both governmental and NGO workers – an approach which was novel for this region, and gave individuals from these two sectors additional chances to interface and develop mutual respect for their expertise.

Outcomes

An October 2013 midterm evaluation of this approach found better access to health care for key populations over baseline in all targeted localities. Specifically:

- A large majority of key populations in all localities reported having **improved access to health care services at primary health care level**, where they could receive a wider range of services than in specialty facilities.
- **Higher client satisfaction** rates were reported, particularly in relation to the quality of STI treatment, HIV testing and treatment, ART, MAT, gynecological and TB diagnostics and treatment services.
- Across all localities, key populations reported **positive changes in the attitudes of the health care providers** towards them at the primary care level, making them more likely to seek care when needed.
- Regular meetings of CCs resulted in **improved relationships between NGOs and governmental health service providers**, allowing them to problem-solve jointly and move towards a true case management model where providers from different sectors interact for the benefit of patients without added monetary incentives

Suggested Next Steps

- The Quality Project continue to support Coordination Councils throughout Year 5.
- That future USAID projects consider using the Coordination Council model, in its current or an adapted form, as a mechanism for solving persistent issues in access to care for key populations.
- That CCMs and Global Fund Grant Implementation Units consider how Coordination Councils may be involved in local oversight and/or monitoring of grant implementation.
- That, in countries where relatively robust continuing medical education systems exist (e.g. Kyrgyzstan), government health care worker trainings on serving key populations be institutionalized and continued, with support from USAID as needed.
- That future USAID projects focus on exploring national mechanisms for sustainable, consistent training of NGOs using the many available curricula developed by the Quality Project and others; any developed training system should have a nationally-recognized certification process associated with it, and correspond to a set of national standard operating procedures for HIV service NGOs.

Further Reading

Burrows, Dave; Shapoval, Anna; Bolotbaeva, Aisuluu. October 2013. Technical Report: Coordination Councils: Increasing Access by Key populations to HIV and Health Services – Model Description and Midterm Evaluation. USAID Quality Health Care Project in the Central Asian Republics, Abt Associates Inc.

Burrows, Dave; McCallum Lou; Parsons, Danielle; Manukyan, Aram; Coughlan, Marie; Bolotbaeva, Aisuluu; Kudussova, Elena; Musaeva, Zarina; and Seitalieva, Chinara. *Improving access for Most-at-Risk Populations to appropriate health services in selected localities: Design and Baseline.* Bethesda, MD. Quality Health Care Project in the Central Asian Republics, Abt Associates Inc.